Department of Veterans Affairs

VA TRANSPLANT REFERRAL FORM

This form, with all required documents, plus 3 copies of the entire packet should be mailed by the primary VAMC to:

Manager, VA Transplant Program (111)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

For Information About:
Bone Marrow, Heart, or Lung **Telephone No. 202-273-8493**
Liver, Kidney or Kidney/Pancreas **Telephone No. 202-273-8492**

OR 1-800-60-HEART (1-800-604-3278)

PART I *(All sections of Part I must be completed by the primary VAMC)*

TYPE OF TRANSPLANT
☐ BONE MARROW ☐ HEART ☐ LUNG ☐ HEART/LUNG ☐ LIVER ☐ KIDNEY ☐ KIDNEY/PANCREAS

PRIMARY VAMC WHERE PATIENT IS ENROLLED *(City, State)*

A1. PATIENT'S SOCIAL SECURITY NUMBER	A5. SUPPORT PERSON *(Relationship)*
A2. PATIENT'S NAME (Last, First, Middle Initial)	A6. SUPPORT PERSON'S NAME *(Last, First, Middle Initial)*
A3. PATIENT'S ADDRESS (Street, City, State and Zip Code)	A7. SUPPORT PERSON'S ADDRESS *(Street, City, State and Zip Code)*
A4. PATIENT'S TELEPHONE NUMBERS HOME: WORK:	A8. SUPPORT PERSON'S TELEPHONE NUMBERS HOME: WORK:

B. Must be completed and signed by Chief, Health Administration Service (HAS), or equivalent, thereby certifying patient is eligible for care and travel. Copy of patient's eligibility information must be attached.

B1. SERVICE CONNECTED ☐ YES ☐ NO	B2. CARE ELIGIBLE ☐ YES ☐ NO	B3. TRAVEL ELIGIBLE ☐ YES ☐ NO

B4. HAS SIGNATURE AND TITLE	B5. TELEPHONE NUMBER	B6. DATE

C. VA STAFF PHYSICIAN MUST PROVIDE ALL INFORMATION

C1. DATE OF BIRTH	C2. AGE	C3. HEIGHT	C4. WEIGHT	C5. IS PATIENT AMBULATORY?
C6. INPATIENT ☐ YES ☐ NO	C7. ICU ☐ YES ☐ NO	C8. OUTPATIENT ☐ YES ☐ NO	C9. RETRANSPLANT ☐ YES ☐ NO	

C10. PATIENT'S PRIMARY DIAGN0SIS

NOTE: *If C12, C15, and C18 are Yes, indicate details in physician referral letter and psych and social evaluations.*

C11. HISTORY OF ALCOHOL USE ☐ YES ☐ NO	C12. DATES OF ALCOHOL USE	C13. DATES OF ABSTINENCE
C14. HISTORY OF SUBSTANCE ABUSE ☐ YES ☐ NO	C15. DATES OF SUBSTANCE ABUSE	C16. DATES OF ABSTINENCE
C17. HISTORY OF TOBACCO USE ☐ YES ☐ NO	C18. DATES OF TOBACCO USE	C19. DATES OF ABSTINENCE

C20. REFERRING PHYSICIAN'S NOTES *(e.g., specific Transplant Center requested by patient, timing of evaluation-critical, urgent, stable)*

(Continued on next page)

PATIENT'S NAME	SOCIAL SECURITY NUMBER

All transplant referrals must include the following ***GENERAL*** and ***ORGAN SPECIFIC*** information. **NOTE:** *Non-invasive test results/clinical lab tests and psych and social evaluations must be no older than 3 months; invasive test results should be no older than 9 months.* **Referrals will not be processed without documented evidence of required tests, procedures, and evaluations as listed below.**

PART I *(Continued)* - GENERAL INFORMATION: Required for all types of transplants referrals.

☐ **VA staff physician summary letter** ☐ **Discharge summary of last hospitalization** ☐ **Interim summary** (if current inpatient)

Evaluations: ☐ **Social** ☐ **Psych** ☐ **Dental** ☐ **List of current medications**

Blood Type: ☐ **A** ☐ **B** ☐ **O** ☐ **AB** ☐ **RH pos/neg**

Serologies: ☐ **HBsAg pos/neg** ☐ **HBsAb pos/neg** ☐ **HCV pos/neg** ☐ **HIV pos/neg** ☐ **CMV IgG pos/neg** ☐ **RPR/VDRL pos/neg**

Procedures ☐ **CXR** ☐ **EKG** ☐ **PFT/DLCO** ☐ **Echocardiogram** ☐ **Thallium** (if history of hypertension, angina, or cardiac disorder)

☐ **PPD** ☐ **Pathology Report** (for any surgical procedure)

Labs: ☐ **CBC** ☐ **UA** ☐ **Chemical Profile** ☐ **Coags** ☐ **TSH** ☐ **T4** (if TSH is abnormal)

☐ **24-Hour Creatinine Clearance** ☐ **Urine Toxicology Screen pos/neg** ☐ **Blood ETOH Screen** (if history) **pos/neg**

ORGAN SPECIFIC INFORMATION

BONE MARROW:
- ☐ Results of **diagnostic bone marrow aspirate and biopsy**
- ☐ Results of **post-chemotherapy sensitivity**
- ☐ Results of **MUGA/EF** (if post-chemotherapy)
- ☐ Results of **HLA typing** (if allogenic requested)
- ☐ Results of **CT/MRI or Bone Scan**

HEART:
- ☐ Results of **right and left cardiac catheterization**
- ☐ Results of trial of **vasodilators** (if pulmonary pressures are elevated)
- ☐ Results of **MUGA/EF** (left and right)
- ☐ Results of **MV0 $_2$**
- **NYHA Class:** _____

LUNG:
- ☐ Results of **right cardiac catheterization** (if diagnosis of primary pulmonary hypertension or cor pulmonale)
- ☐ Results of **left cardiac catheterization** (if age >50 or CAD)
- ☐ Results of **nuclear gated with left and right ejection fractions**
- ☐ Results of **polysomnography study** (if evidence of sleep apnea)
- ☐ Results of **lung biopsy** (if available)
- ☐ Results of **chest CT** (with contrast)
- ☐ Results of **alpha one anti-trypsin level**
- ☐ Results of **arterial blood gases**

LIVER:
- ☐ Results of **HBcAb pos/neg**
- ☐ Results of **HAV pos/neg**
- ☐ Results of **HBeAg, HBeAb, and DNA** (if HBsAg is positive)
- ☐ Results of **doppler ultrasound** (to measure vessel patency)
- ☐ Results of **colonoscopy or flexible sigmoidoscopy** (if age >50)
- ☐ Results of **AFP levels**
- ☐ Results of **liver biopsy** (if available)
- ☐ Results of **abdominal CT or MRI**

KIDNEY:
- ☐ Results of **GI consult and liver function tests** (if HCV positive)
- ☐ Results of **colonoscopy or flexible sigmoidoscopy** (if age >50)
- ☐ Results of **liver biopsy** (if HCV PCR positive)
- ☐ **PSA** (if age >50)

NOTE: *After review of referral packet as outlined above, additional information/test results may be requested by Review Board members.*

VA STAFF PHYSICIAN *(Print Name and Sign)*	TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS
VA CONTACT PERSON *(For Questions/Problems)*	TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS
VA CHIEF OF STAFF *(Print Name and Sign)*	TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS

PART II - To be completed by Manager, VA Transplant Program, Washington, D.C.

FINAL DECISION: ☐ **APPROVE** TRANSPLANT CENTER ASSIGNED TO: _____ ☐ **DEFER** ☐ **DISAPPROVE** ☐ **CANCEL**

Comments: _____

VA TRANSPLANT PROGRAM OFFICIAL *(Print Name and Sign)*	DATE